STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155681	B. WING		06/28/2011
NAME OF F	ROVIDER OR SUPPLIER		I	ADDRESS, CITY, STATE, ZIP CODE	
				REEN VALLEY RD	
AUTUMN	I WOODS HEALTH		NEW A	LBANY, IN47150	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was for	r a Post Survey Revisit	F0000		
		ertification and State	1 0000		
		y completed on May 12,			
	2011.	y completed on way 12,			
	2011.				
	Survey Dates: Ju	une 27 28 2011			
	Burvey Bates. 30	une 27, 20, 2011			
	Facility number:	002657			
	Facility number: 002657 Provider number: 155681				
	Aim number: 200308930				
	Aim number: 200308930				
	Survey team:				
	Avona Connell, I	RN TC			
	Donna Groan, RI	N			
	Dorothy Navetta	, RN			
	Gloria Reisert, M				
	Census bed type:	:			
	SNF: 38				
	SNF/NF: 37				
	Total: 75				
	Census payor typ	pe:			
	Medicare: 24				
	Medicaid: 19				
	Other: 32				
	Total: 75				
	Sample: 09				
	Supplemental sar	mple: 03			
		_			
	These deficiencie	es also reflect State			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 002657

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155681 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED A. BUILDING 00 (X3) DATE SURVE COMPLETED		ETED				
	PROVIDER OR SUPPLIER			2911 GF	DDRESS, CITY, STATE, ZIP CODE REEN VALLEY RD LBANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	-	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0155 SS=D	to refuse to partici research, and to for directive as specifi section. Based on record interview, the fact 1 resident requirisintravenous fluid supplemental sar refuse treatment informed the staff (Resident #29) Finding includes Review of the cli #29 on 6/27/2012 the resident had concluded, but we of the vaginal are	nple of 3 the right to even after the resident If she did not want the IV. nical record for Resident at 2:00 p.m., indicated	F01	55	1. Resident #29 reassessed no signs of distress or recollection of procedure.2. residents these employees of for have the potential to be affected and therefore the IV nurse, LPN #3, and CNA #1 were re-educated by Home Clinical Support on a resider right to refuse treatment accessed from the Indiana S Ombudsman program.3. All were re-inserviced by Home Office Clinical Support or DH a resident's right to refuse treatment accessed from the Indiana State Ombudsman program.4. Rounding will be conducted by the Social Wor or designee to include visual monitoring of staff adherence	All sare Office tt's tate staff IS on ker ly	07/22/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1F2812

Facility ID:

002657

If continuation sheet

Page 2 of 21

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155681
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A nursing note dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN47150 (X5) PROVIDERS PLAN OF CORRECTION COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) DATE Resident Rights in addition to interviewing a minimum of one resident during each round. This will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the OA
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH OF PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) OT THE APPROPRIATE DEFICIENCY) DATE Resident Rights in addition to interviewing a minimum of one resident during each round. This will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the OA
AUTUMN WOODS HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (A nursing note dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get (X5) PREFIX (EACH ODERICTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH ODERICTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE C
AUTUMN WOODS HEALTH CAMPUS (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG depression and insomnia. A nursing note dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get NEW ALBANY, IN47150 (X5) PREFIX (EACH OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Resident Rights in addition to interviewing a minimum of one resident during each round. This will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the OA
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A nursing note dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMPLETION DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE (CROSS-REFERENCED TO THE
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY) (EACH DEFICIENCY) (EACH DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (IN A TION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (IN A TION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (IN A TION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (IN A TION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (IN A TION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (IN A TION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (IN A TION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (IN A TION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICE TO THE AP
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A nursing note dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Resident Rights in addition to interviewing a minimum of one resident during each round. This will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the OA
depression and insomnia. A nursing note dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get Resident Rights in addition to interviewing a minimum of one resident during each round. This will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the OA
interviewing a minimum of one resident during each round. This will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the OA
A nursing note dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get resident during each round. This will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the OA
A nursing note dated 6/27/2011 at 8:00 a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get will occur a minimum of 5 times per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the OA
a.m. indicated the resident was not eating or taking fluids or meds and the daughter was concerned the infection might get per week for 1 month and 3 times per week for 2 months. Results of this rounding and interviews will be reviewed by the OA
or taking fluids or meds and the daughter was concerned the infection might get per week for 2 months. Results of this rounding and interviews will be reviewed by the OA
was concerned the infection might get of this rounding and interviews will be reviewed by the OA
I I will be reviewed by the () Δ I
Confinince and if 100%
dehydrated. The note also indicated the compliance is not reached, then
resident was in a very foul mood slapping rounding and interviews will continue until 3 months of
at staff during care and screaming out. A
new order from the physician was reached.
received for staff to attempt to place a
midline [IV].
At 1:00 p.m., the IV nurse arrived and
began the process of inserting the special
line with LPN #3 assisting him. Although
the nurse could be heard trying to reassure
the resident and explain the procedure, the
resident could be heard from behind the
closed doors yelling out "Oh no you don't.
Get away. No." A few minutes later, LPN
#3 requested CNA #1 [certified nursing
assistant] to come into the room and help
her with the resident while they were
trying to get the IV in. The resident
continued to yell.
Between 1:30 p.m. and 2:00 p.m. during
the observation of the IV procedure, while
the IV nurse was on the left side trying to
get the line in and telling the resident to
hold still, LPN #3 was observed to be
holding the resident's right hand with her

002657

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681			LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/28/2	ETED	
	PROVIDER OR SUPPLIER		p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE REEN VALLEY RD LBANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	other arm across #1 was observed to both of the res she would not m. Throughout this was heard to yel her legs to which replied that they not done yet, she me", and at one IV nurse, tell hir hurting my arm. continued to hold chest/hand until At the end of the left arm was obs and taped to the She also remained staff to get out at yelling out while the bathroom per During an interve 6/27/2011 at 2:11 reason she did not the insertion of the start was observed.	the resident's chest. CNA to be holding down one sident's legs off and on so ove during the procedure. observation, the resident I for the staff to get off the LPN and IV nurse could not as they were the "hated" them, "get off point while looking at the mutice "Please, you're " The LPN and the CNA d the resident's legs and the procedure was done. The procedure was done. The procedure, the resident's the reveal to be stretched out overbed table at the wrist. The ded vocal in telling the mutical "Oh, I hurt" with the attempting to take her to mutical the request. The LPN #3 on The procedure was done. The procedure was done. The procedure, the resident's the reveal to be stretched out overbed table at the wrist. The procedure was done. The p			CROSS-REFERENCED TO THE APPROPRIA	TE	
	comprehended the own good and we placed. She felt to make a choice to	esident understood nor ne idea that it was for her ould help her for it to be the resident could not o refuse and it was the st for her to have it.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	A. BUILDING	00 	COMP 06/28/2	LETED
	PROVIDER OR SUPPLIER		2911 G	ADDRESS, CITY, STATE, ZIP CODI SREEN VALLEY RD ALBANY, IN47150		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Nursing] on 6/27 indicated the staff what they were done physician she was On 6/28/2011 at presented a copy and "Move in Haresidents and fan admission. Revieincluded, but wer 18: You have the nursing care and means that: 1. You	d DoN [Director of /2011 at 2:35 p.m., both f should have stopped oing and notified the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	(X2) MU A. BUII B. WIN	DING	00	(X3) DATE S COMPL 06/28/2	ETED
	PROVIDER OR SUPPLIER			2911 GF	DDRESS, CITY, STATE, ZIP CODE REEN VALLEY RD BANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
F0157 SS=D	resident; consult vand if known, notification representative or a when there is an a resident which respotential for requires significant changemental, or psychodeterioration in he psychosocial statuconditions or clinical ter treatment significant changemental services and verse consection of treatments for or dischart facility as specified. The facility must a resident and, if known there is a change in resident and, if known there is a change in resident state law or regular paragraph (b)(1). The facility must resident's legal regionally member. Based on recordinterview, the facility must resident's legal regionally member. Based on recordinterview, the facility must resident's legal regionally member. Based on recordinterview, the facility must resident's legal regionally member.	is in either life threatening cal complications); a need to inificantly (i.e., a need to sting form of treatment due quences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the pown, the resident's legal interested family member arange in room or roommate pecified in §483.15(e)(2); or ent rights under Federal or ations as specified in	F0	157	1. Resident #29 reassessed no signs of distress or recollection of procedure.2. residents these employee ca have the potential to be affect and therefore the IV nurse, L #3, and CNA #1 were	All re for cted	07/25/2011
	=	anyway. (Resident #29)			re-educated by Home Office Clinical Suport or DHS on a resident's right to refuse		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1F2812

Facility ID:

002657

If continuation sheet

Page 6 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155681 06/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2911 GREEN VALLEY RD **AUTUMN WOODS HEALTH CAMPUS** NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE treatment as oulined by the Indiana State Ombudsman Finding includes: program and the importance of MD notification in the event this Review of the clinical record for Resident right is exercised. 3. All staff were re-inserviced by Home #29 on 6/27/2011 at 2:00 p.m., indicated Office Clinical Suport or DHS on the resident had diagnoses which a resident's right to refuse included, but were not limited to, shingles treatment as oulined by the of the vaginal area, dementia with Indiana State Ombudsman disturbance of mood and behavior, program and the importance of MD notification in the event this depression and insomnia. right is exercised. 4. Rounding will be conducted by the Social A note in the nursing notes dated Worker or designee to include 6/27/2011 at 8:00 a.m. indicated the visually monitoring of staff adherence to Resident Rights in resident was not eating or taking fluids or addition to interviewing a meds and the daughter was concerned the minimum of one resident during infection might get worse or that the each round. This will occur a minimum of 5 times per week for resident would become dehydrated. The 1 month and 3 times per week for note also indicated the resident was in a 2 months. Results of this very foul mood slapping at staff during rounding and interviews will be care and screaming out. A new order reviewed by the QA Committe from the physician was received for staff and if 100% compliance is not reached, then rounding and to attempt to place a midline [IV]. interviews will continue until 3 months of consistent compliance At 1:00 p.m., the IV nurse arrived and of 100% is reached. began the process of inserting the special line with LPN #3 assisting him. Although the nurse could be heard trying to reassure the resident and explain the procedure, the resident could be heard from behind the closed doors yelling out "Oh no you don't. Get away. No." A few minutes later, LPN #3 requested CNA #1 [certified nursing assistant] to come into the room and help her with the resident while they were

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1F2812

Facility ID:

002657

If continuation sheet

Page 7 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155681		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 06/28/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		1	REEN VALLEY RD		
	WOODS HEALTH			<u> </u>	_BANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
PREFIX TAG	*	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
1710		IV in. The resident	+	1110			DITTE
	continued to yell						
	continued to yen						
	Between 1:30 p.m. and 2:00 p.m. during						
	the observation of	of the IV procedure, while					
	the IV nurse was	s on the left side trying to					
	get the line in an	d telling the resident to					
	hold still, LPN #	3 was observed to be					
	holding the resident's right hand with her						
	other arm across the resident's chest. CNA						
	#1 was observed to be holding down one						
	to both of the resident's legs off and on so						
	she would not move during the procedure.						
	Thursday 41sis	-1					
	_	observation, the resident					
	_	I for the staff to get off					
	_	n the LPN and IV nurse					
	1 ^ -	could not as they were					
	I -	e "hated" them, "get off point while looking at the					
		n twice "Please, you're					
		" The LPN and the CNA					
	1	d the resident's legs and					
		the procedure was done.					
		procedure, the resident's					
		erved to be stretched out					
		overbed table at the wrist.					
	1 ^	ed vocal in telling the					
		nd "Oh, I hurt" with					
	1 -	e attempting to take her to					
	the bathroom per						
	During an interv	iew with LPN #3 on					
	6/27/2011 at 2:10	0 p.m., she indicated the					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CO	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155681	B. WING			06/28/2	011
	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE REEN VALLEY RD		
AUTUMN	WOODS HEALTH	CAMPUS		NEW AL	BANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG		ot let the resident refuse		TAG	BEIGENCI		DATE
		he IV was because she					
		esident understood nor					
	own good.	ne idea that it was for her					
	own good.						
	During an intervi	iew with the					
	_	d DoN [Director of					
		7/2011 at 2:35 p.m., both					
	indicated the staff should have stopped what they were doing and notified the						
	physician she was combative.						
	1 3						
	On 6/28/11 at 8:3	30 a.m., the clinical					
	record was review	wed for Resident #29 and					
	documentation w	vas lacking in the nurses					
	notes of the phys	sician being notified					
	during and/or aft	er the IV insertion related					
	to the residents b	ehavior.					
	_	was cited on 5/27/11. The					
	=	implement a systemic					
	plan of correction	n to prevent recurrence.					
	3.1-5(a)(3)						
F0224	The facility must d	evelop and implement					
SS=D	•	d procedures that prohibit					
		lect, and abuse of residents					
		ion of resident property. ord review, observation	F02	24	1. a. Resident #29 reassess	ed	07/25/2011
	71. Dasca on 1000	ora review, observation	1.02.	<u>-</u> -	with no signs of distress or		07/23/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155681 06/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2911 GREEN VALLEY RD **AUTUMN WOODS HEALTH CAMPUS** NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE recollection of procedure. b. Both and interview, the facility failed to allow 1 Residents#78 & #79 continued to of 1 resident requiring insertion of an receive medications as ordered intravenous fluid line [IV] in a and neither received a bill for the supplemental sample of 3 the right to misappropriated medications. refuse treatment even after the resident 2. a. All residents these employees are for have the informed the staff she did not want the IV. potential to be affected and (Resident #29) therefore the IV nurse, LPN #3, and CNA #1 were re-educated by B. Based on record review and interview Home Office Clinical Suport regarding the federal and state the facility failed to ensure resident regulation regarding medication was secure for 2 of 2 residents mistreatment, neglect and reviewed with missing medications in a abuse of residents, b. LPN #2 supplemental sample of 3. (Resident #78, and RN#1 were terminated. All current resident records were 79) reviewed to ensure no other resident medications were Findings include: missappropriated with no additional findings.3. All staff were re-educated by Home Office A. 1. Review of the clinical record for Clinical Suport or DHS regarding Resident #29 on 6/27/2011 at 2:00 p.m., the federal and state regulation indicated the resident had diagnoses regarding mistreatment, neglect which included, but were not limited to, and abuse of residents and misappropriation of property. In shingles of the vaginal area, dementia addition, all nurses and QMAs with disturbance of mood and behavior, were in-serviced on the revised depression and insomnia. campus controlled drug destruction policy which includes nursing adminstration and A note in the nursing notes dated another staff nurse jointly 6/27/2011 at 8:00 a.m. indicated the conducting the destruction as resident was not eating or taking fluids or recommended per PCA meds and the daughter was concerned the Pharmaceutical.4. a. Rounding will be conducted by the Social infection might get worse or that the Worker or designee to include resident would become dehydrated. The visually monitoring of staff note also indicated the resident was in a adherence to Resident very foul mood slapping at staff during Rights/Abuse Prevention in addition to interviewing a care and screaming out. A new order

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1F2812

Facility ID:

002657

If continuation sheet

Page 10 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155681	B. WIN			06/28/2	U11
NAME OF	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
				1	REEN VALLEY RD		
AUTUM	N WOODS HEALTH	CAMPUS		NEW AI	LBANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1	an was received for staff			minimum of one resident dur each round. This will occur	•	
	to attempt to pla	ce a midline [IV].			minimum of 5 times per wee		
					1 month and 3 times per wee		
	At 1:00 p.m., the IV nurse arrived and began the process of inserting the special line with LPN #3 assisting him. Although the nurse could be heard trying to reassure the resident and explain the procedure, the resident could be heard from behind the closed doors yelling out "Oh no you don't. Get away. No." A few minutes later, LPN #3 requested CNA #1 [certified nursing				2 months. Results of this		
					rounding and interviews will		
					reviewed by the QA Committ		
					and if 100% compliance is no reached, then rounding and	ot	
					interviews will continue until	3	
					months of consistent complia		
					of 100% is reached. b. The	DHS	
					or designee will conduct aud		
					5 residents one time per wee	ek for	
	assistant] to come into the room and help her with the resident while they were				3 months by obtaining a controlled substane delivery		
					report from the pharmacy an	d	
					cross-checking this informati		
		IV in. The resident			with the correlating resident		
	continued to yell	I.			narcotic count sheet, and the actual narcotic count. Resul		
	D.4 1.20	12.00 1			this audit will be reviewed by		
	1	m. and 2:00 p.m. during			QA committee and continue		
		of the IV procedure, while			monthly until 3 months of 10	0%	
		s on the left side trying to			compliance is reached.		
	1 -	e resident's arm and					
	_	ent to hold still, LPN #3					
		be holding the resident's					
	"	ner other arm across the					
	resident's chest.	CNA #1 was observed to					
	be holding down	one to both of the					
	resident's legs of	ff and on so she would not					
	move during the	procedure.					
	Throughout this	observation, the resident					
	was heard to yel	l for the staff to get off					
	1	n the LPN and IV nurse					
		could not as they were					
	1 -	e "hated" them, "get off					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155681		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 06/28/2	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1 00:20:2	
NAME OF	PROVIDER OR SUPPLIEF	₹			REEN VALLEY RD		
	N WOODS HEALTH			NEW AL	_BANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	•	· · · · · · · · · · · · · · · · · · ·	+	IAG	,		DAIL
	me", and at one point while looking at the IV nurse, tell him twice "Please, you're						
	hurting my arm." The LPN and the CNA						
	"	d the resident's legs and					
		the procedure was done.					
		e procedure, the resident's					
		erved to be stretched out					
	and taped to the overbed table at the wrist.						
	She also remained vocal in telling the staff to get out and "Oh, I hurt" with yelling out while attempting to take her to						
	the bathroom per her request.						
	During an interview with LPN #3 on						
	6/27/2011 at 2:1	0 p.m., she indicated the					
	reason she did no	ot let the resident refuse					
	the insertion of t	he IV was because she					
	did not feel the r	resident understood nor					
	comprehended th	he idea that it was for her					
	own good and w	ould help her for it to be					
	placed. She felt	the resident could not					
	make a choice to	refuse and it was the					
	daughter's reque	st for her to have it.					
	During an interv						
		nd DoN [Director of					
		7/2011 at 2:35 p.m., both					
	1	ff should have stopped					
	I -	doing and notified the					
	physician she wa	as combative.					
	Review of the C	are Plans for Resident					
		following care plan with					
	1	on date of 1/10 and					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE: COMPL 06/28/2	ETED
	PROVIDER OR SUPPLIER		1	STREET A	DDRESS, CITY, STATE, ZIP CODE REEN VALLEY RD BANY, IN47150	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	review dates of 9 3/10/11: "Proble Physically Abusi Inappropriate, Vi Care, negative, r yelling out." Int were not limited non-confrontatio Anticipate care r before the reside stressed. Monito attempt to deterr Consider locatio involved, etc. Ex before starting at Reapproach reside becomes agitated observation of th attempted were if during the proce On 6/27/2011 at presented a copy policy and proce Neglect - Proced of this policy at was not limited to name] has developrocesses, which prevention and r alleged resident Procedure: 1. [fa	m: Behavior Problem - ve, Socially erbally Abusive, Resists means statements to staff, erventions included, but to, "Provide mal environment for care; meeds and provide them must becomes overly respectively behavior episodes and mine underlying cause. must all procedures must allow time to adjust. dent later when she d". Documentation and/or mese interventions being acking prior to and dure. 1:00 p.m., the DoN of the facility's current dure on "Abuse and mural Guidelines". Review whis time included, but o, "Purpose: [facility oped and implemented a strive to ensure the eporting of suspected or abuse and neglect. cility name] had ocesses in an effort to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155681		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SU COMPLET 06/28/201	TED	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
				1	REEN VALLEY RD		
AUTUMN	I WOODS HEALTH	CAMPUS		NEW AL	BANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE (COMPLETION DATE
IAG	environment"	LSC IDENTIFTING INFORMATION)	+	IAG	BH ICE. C. I		DATE
	environinent						
	On 6/28/2011 at	8:55 a m the DoN					
	On 6/28/2011 at 8:55 a.m., the DoN presented a copy of the most recent						
		o all staff on "Resident					
	_	ated 3/31/2011. Review					
	of the signature page indicated LPN #3						
	and CNA #1 had attended this inservice.						
	Review of the content of information given to the staff included, but was not						
	limited to, "Prevention and Reporting of						
	Suspected Resident/Patient Abuse and						
	Neglect:Traini	ng: a. provide training for					
	new employees t	hrough orientation and					
	with ongoing tra	ining programs2.					
	Training will inc	lude, but is not limited					
	to:Appropriate	interventions to deal					
	with aggressive	or catastrophic reactions					
		Occumentation of training					
		ed with inservice records					
		3. Prevention: a. Assure					
	that prevention to	-					
	*	the campus. Identify,					
	· ·	rvene in situations where					
	_	elect are more likely to					
	· ·	y include, but are not					
		alysis of:Assigned staff					
		wledge of individual					
		dentification of residents or behaviors which might					
	lead to conflict o	•					
	icau to commet o	n negicei					
	B. On 6/6/11 at	7:25 a.m., the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1F2812 Facility ID:

002657

If continuation sheet Page 14 of 21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	incident: "On ex (Licensed Practic DHS (Director or reported that 22 narcotic sheet we reported that [nathe vials of morpharcotics with [nathe vials of morpharcotics with [nathe vials of morpharcotics with [nathe vials of morpharcotic sign out (Resident #78). morphine vials we narcotic sign out Neither nurse cathe morphine vials investigation, it is physician had not discontinue the ralso noted that [named] RN #1 Lortab (pain narcotic sign out (Resident #79) the discontinue the police are involved on going investigation. The clinical rewas reviewed on The resident's discontinue or the resident's discontinue or the resident of the	ported the following rening of June 6th, LPN cal Nurse) #1 called the f Health Services) and vials of Morphine and ere missing. It was med] LPN #2, removed whine to destroy these samed] RN (registered obysician had given an use administration of this me resident involved Upon investigation, the vere not found and the exheet was missing. In accurately account for alls or narcotic sheet. Upon was determined that the extigurent an order to morphine. Investigation mamed] LPN #2 and mad wasted 10 doses of cotic) for another resident mat there was not an order to medication. The local red with the facility in the action." Second for Resident #78 and 6/27/11 at 1:45 p.m. agnoses included, but to arthritis. Physician's st dated 5/28/11 included, sted to; "Morphine 2 mg						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1F2812 Facility ID:

002657

If continuation sheet

Page 15 of 21

AND PLAN OF CORRECTION ID		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/28/2	ETED
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN47150				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	(milligram) q. (eneeded) pain IV (intramuscularly hour prn severe physician's Telep 5/31, 6/5 and 6/6 discontinuation of the resident was on 4/25/11 with The resident's diwere not limited arthritis. Signed 2011 included, be Lortab 5/500 tabe every 4 hours as severe pain "Orders on 5/27, discontinuation of the police she has #1 took 11 vials. On 6/28/11 at 12 provided the Insertion of the police she has #1 took 11 vials. On 6/28/11 at 12 provided the Insertion of the police she has #1 took 11 vials.	very) 4 hour prn (as (intravenous) or IM); Morphine 4 mg q. 4 pain" Subsequent phone Orders on 5/30, 6 lacked any of Morphine orders. ecord for Resident #79 6 6/27/11 at 1:50 p.m. 6 admitted to the facility a recent pelvic fracture. agnoses included, but to: arthritis and temporal and dated orders for May ut was not limited to: let Give 1 tablet orally needed for moderate to Physician's Telephone and 6/3 lacked any of Lortab. In the DON on 6/27/11 at cated LPN #2 admitted to d taken 11 vials and RN E:20 p.m., the DHS ervice Resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155681			A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER AUTUMN WOODS HEALTH CAMPUS			B. WING OU/20/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 2911 GREEN VALLEY RD NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Suspected Resided Neglect included Definitions: Mistain and Policy includes, but is deliberate misplay wrongful, tempora a resident's below On 6/27/11 at 12 provided a Narco signed on 4/4/11 by LPN #2 which limited to: "Wastamedication has be discharged, medication has be discharged, medication de MUST sign the rather narcotic sheet on 6/27/11 at 12 indicated LPN#2 on dividing the Narcotic sheet."	2:10 p.m., the DHS 2:11 p.m., the DHS 2:11 p.m., the DHS 2:12 p.m., the DHS 2:13 p.m., the DHS 2:14 p.m., the DHS 2:15 p.m., the DHS 2:16 p.m., the DHS 2:17 p.m., the DHS 2:17 p.m., the DHS 2:18 p.m., the DHS 2:19 p.m., the DHS 2:19 p.m., the DHS 2:19 p.m., the DHS 2:10 p.m., the DHS 2:10 p.m., the DHS 2:11 p.m., the DHS 2:12 p.m., the DHS 3:12 p.m., the DHS 3:13 p.m., the DHS 4:14 p.m., the DHS 4:15 p.m., the DHS 5:16 p.m., the DHS 6:17 p.m., the DHS 6:18 p.m., the DHS 7:18 p.m., the DHS 8:19 p.m., the DHS 8:19 p.m., the DHS 9:19 p.m., th						

002657

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155681 06/28/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2911 GREEN VALLEY RD **AUTUMN WOODS HEALTH CAMPUS** NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The services provided or arranged by the F0282 facility must be provided by qualified persons SS=D in accordance with each resident's written plan of care. Based on record review and interview the 1. Both Residents#78 & #79 F0282 07/25/2011 continued to receive medications facility failed to ensure the policy and as ordered and neither received a procedure for drug destruction was bill for the misappropriated followed for 2 of 2 residents reviewed for medications. 2. LPN #2 and drug destruction in a supplemental sample RN#1 were terminated. All current resident contolled of 3. (Resident #78, 79) substance records were reviewed to ensure no other resident Findings include: medications were missappropriated with no additional findings.3. All nurses On 6/6/11 at 7:25 a.m., the facility and QMAs were in-serviced by reported the following incident: "On the Home Office Clinical Support evening of June 6th, LPN (Licensed or DHS on the revised campus Practical Nurse) #1 called the DHS controlled drug destruction policy which includes nursing (Director of Health Services) and reported adminstration and another staff that 22 vials of Morphine and narcotic nurse jointly conducting the sheet were missing. It was reported that destruction as recommended per PCA Pharmaceutical. 4. The [named] LPN #2, removed the vials of DHS or designee will conduct morphine to destroy these narcotics with audits of 5 residents one time per [named] RN (registered nurse) #1. The week for 3 months by obtaining a physician had given an order to controlled substane delivery discontinue administration of this report from the pharmacy and cross-checking this information medication for the resident involved with the correlating resident (Resident #78). Upon investigation, the narcotic count sheet, and the morphine vials were not found and the actual narcotic count. Results of narcotic sign out sheet was missing. this audit will be reviewed by the QA committee and continue Neither nurse can accurately account for monthly until 3 months of 100% the morphine vials or narcotic sheet. Upon compliance is reached. investigation, it was determined that the physician had not given an order to discontinue the morphine. Investigation

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL	ETED
		155681	B. WIN	IG		06/28/2	011
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
AUTUMN WOODS HEALTH CAMPUS				1	REEN VALLEY RD _BANY, IN47150		
				<u> </u>	_DAN1, 11147 150		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
-	also noted that [named] LPN #2 and			-			
	_	had wasted 10 doses of					
	1	cotic) for another resident					
	~	hat there was not an order					
	1 '	e medication. The local					
	police are involv	red with the facility in the					
	ongoing investig						
	1. The clinical re	ecord for Resident #78					
	was reviewed on	6/27/11 at 1:45 p.m.					
	The resident's di	agnoses included, but					
	were not limited	to arthritis. Physician's					
	Telephone Order	rs dated 5/28/11 included,					
	but was not limit	ted to; "Morphine 2 mg					
	(milligram) q. (e	very) 4 hour prn (as					
	needed) pain IV	(intravenous) or IM					
	(intramuscularly); Morphine 4 mg q. 4					
	hour prn severe	pain" Subsequent					
	Physician's Telep	phone Orders on 5/30,					
	5/31, 6/5 and 6/6	lacked any					
	discontinuation of	of Morphine orders.					
		ecord for Resident #79					
		6/27/11 at 1:50 p.m.					
		s admitted to the facility					
		a recent pelvic fracture.					
		agnoses included, but					
		to: arthritis and temporal					
	1	and dated orders for May					
	1	ut was not limited to:					
		let Give 1 tablet orally					
	_	needed for moderate to					
	_	Physician's Telephone					
	Orders on 5/27,	and 6/3 lacked any					

1		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S COMPL 06/28/2	ETED
		100001	B. WINC	_		06/26/2	011
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE REEN VALLEY RD		
AUTUMN WOODS HEALTH CAMPUS					BANY, IN47150		
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES		<u> </u>	ID PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		of Lortab. The [named]					
	1	olled Drug Record for					
		"Hydrocodone/APAP					
	' -	ablets Gen (generic) for:					
		let was received on					
	· ·	time, 15 tablets were					
	` ′	ses had been given to					
		isposition of remaining Doses flushed quantity 10					
	date 5/26/11 RN						
	Nursing staff failed to have an order for the drug destruction.						
	On 6/27/11 at 12	:10 p.m., the DHS					
		otic In-Service form					
	1 ^	by RN #1 and on 3/28/11					
	-	n included, but was not					
	*	gning below, I am					
	1	rstanding and agreeing to					
	follow the narcot	ic policy and procedure.					
	I am also aware o	of the new narcotic form					
	that must be com	pleted when a narcotic is					
	received, wasted	or empties. I also					
	understand the po	olicy on administering					
	narcotics and the	forms that are required					
	to fill out per Tri	logy's PolicyWasting					
	narcotics: When	a medication has been					
	discontinued, pat						
	medication expir	_					
	1 ^	rses MUST waste the					
		her and document the					
		on; number of medication					
	I -	th nurses MUST sign the					
	narcotic sheetT	Then file the narcotic					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/21/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPI	LETED	
15		155681	B. WING		 	06/28/2011		
			B. WIN					
NAME OF F	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE			
				1	REEN VALLEY RD			
AUTUMN	NWOODS HEALTH	CAMPUS	NEW ALBANY, IN47150					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	sheet in the patie	ents chart "						
	parett in the paret	CIANTO						
	0 (05/11) 10	1 0						
		p.m., the Corporate						
	Nurse Consultan	t indicated RN #1 had the						
	Narcotic inservi	ce on April 4, 2011.						
		•						
	On 6/27/11 at 12	2:17 p.m., the DHS						
		1						
	indicated LPN #2 and RN #1 had wasted							
	the medication for	or Resident #79. She						
	indicated both nurses were terminated.							
	7E1 ' 1 C' '	. 1 05/10/11						
		was cited on 05/12/11.						
	The facility faile	ed to implement a						
	systemic plan of	correction to prevent						
	recurrence.	1						
	recurrence.							
	3.1-35(g)(2)							
F0000								
F9999								
			F9	1999	No deficiency cited.		07/25/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1F2812

Facility ID: 002657

If continuation sheet